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ABSTRACT

A disturbing new movement in the mental health field called "Culture Competence" or "multicultural therapy" threatens to discredit traditional therapy and replace it with identity politics. In its most radical form, multicultural therapy holds that human behavior is primarily culture dependent, that doctors and patients will always experience mistrust and miscommunication if they are of different racial or ethnic groups, and that white therapists should be presumed racists. As extreme as these views may sound, their influence has been indirectly felt in the mainstream. Versions of multicultural therapy, some more moderate than others, are promoted by the federal government, various professional groups, and numerous writers and speakers in the mental health field. The most prominent cultural competitive program in the United States is the Cultural Competence and Diversity Program at San Francisco General Hospital. Doctors in the mental health unit specialize in different patient groups--blacks, Asians, Latinos, gays/lesbians/bisexuals, women, and the HIV-positive. The hospital produces a "curriculum" to guide doctors in treating patients of each group. The city of San Francisco has even created a new specialization for non-doctor health professionals: African American Health Services Specialists. No one believes that race and culture are irrelevant to mental health, but multicultural therapy seeks to establish rigid rules of treatment based on stereotypes and "groupthink." This denies the individual dignity of both doctors and patients. Contains 44 endnotes. (MKA)

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CEO POLICY BRIEF

August, 1996

ED 419 196

Multicultural Mental Health

Does Your Skin Color Matter More Than Your Mind?

By Sally Satel, M.D., and Greg Forster

Executive Summary

"As a member of the White group, what responsibility do you hold for the racist, oppressive, and discriminating manner by which you personally and professionally deal with minorities?" asks a popular textbook for psychotherapists, *Counseling the Culturally Different*.

This racial inquisition is one sample of a disturbing new movement in the mental health field. Called "cultural competence" or "multicultural therapy," this movement threatens to discredit traditional therapy and replace it with identity politics. In its most radical form, multicultural therapy holds that human behavior is primarily culture-dependent, that doctors and patients will always experience mistrust and miscommunication if they are of different racial or ethnic groups, and that white therapists should be presumed racist.

As extreme as these views may sound, their influence has been indirectly felt in the mainstream. Versions of multicultural therapy, some more moderate than others, are promoted by the federal government, various professional groups, and numerous writers and speakers in the mental health field.

The most prominent cultural competence program in the United States is the Cultural Competence and Diversity Program at San Francisco General Hospital. Doctors in the mental health unit at San Francisco General specialize in different patient groups — blacks, Asians, Latinos, gays/lesbians/bisexuals, women, and the HIV-positive. The hospital produces a "curriculum" to guide doctors in treating patients of each group. The city of San Francisco has even gone so far as to create a new racial specialization for non-doctor health professionals: African American Health Services Specialists.

No one believes that race and culture are irrelevant to mental health, but multicultural therapy seeks to establish rigid rules of treatment based on stereotypes and groupthink. This denies the individual dignity of both doctors and patients.

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Introduction

The hot new topic in mental health care is "cultural competence" or "multicultural therapy." The *New York Times* hails it as part of a "new movement in psychiatry that recognizes the cultural trappings patients bring with them."[1] Cultural competence is promoted by the federal government, the American Psychological Association, the American Psychiatric Association, and numerous scholarly books. It pops up regularly on the conference and workshop circuits. It is also a growing part of psychological training: Only a handful of counseling programs required multicultural counseling courses in the 1970s and early 1980s, but recent surveys have found that 42 percent to 59 percent of counseling programs currently require such a course.[2]

Cultural competence ranges from the gratuitous (advising clinicians to "respect" a patient's cultural heritage) to the misguided (believing that human identity and behavior are primarily culture-dependent) to the near-paranoid (presuming that therapists and patients of different racial groups will experience so much miscommunication and mistrust that the therapist must learn a different set of rules for treating patients of a different race). The most radical vision of cultural competence claims that membership in an oppressed group is a patient's most clinically important attribute and that white therapists are racist whether they know it or not. Difficult as it may be to believe, even these radical aspects of the cultural competence doctrine show up in public policy: In the mental health unit of San Francisco General Hospital, each of six "client groups" — blacks, Asians, Latinos, gays/lesbians/bisexuals, women, and the HIV-positive — has its own separate treatment program.

This new movement in psychiatry replaces medical treatment with identity politics. The essential truth of psychotherapy is that an individual's struggle and ultimate capacity to adapt are fought from within the individual, not against an oppressive society. Just as multicultural education has devastated educational standards, multicultural therapy threatens to lock doctors and patients into a rigid framework of racial politics that prevents effective treatment of psychological conditions.

What Is Cultural Competence?

The Office of Minority Health, a unit of the U.S. Public Health Service, distributes an information packet that includes a full page on the definition of "cultural competence." Entitled "Cultural Competence Definition," it explains:

> Cultural competence is the highest step on a continuum that begins with cultural awareness which is the recognition of the specific and special needs of racial or ethnic group. [sic] The next step to reaching cultural competence is achieving cultural sensitivity, in which knowledge and information is gathered in order to understand in an accepting manner

> unique and special needs, beliefs, behaviors and characteristics of racial or ethnic group. [sic] After this step is achieved, the differences between the group being served and the care giver must be recognized, evaluated and valued so that an understanding can be achieved. When the knowledge has been attained it must be applied in the formation of policies that recognize and appreciate these differences. Culturally competent policies and programs must be developed and implemented in a manner that does not conflict or require change of the beliefs and behaviors of those belonging to racial or ethnic group being served. [sic] After culturally competent programs and policies are implemented, ways must also be developed for continual self-evaluation of a cultural competent program's own effectiveness and appropriateness.[3]

This psychobabble is particularly mindnumbing, but it is not wholly atypical of the prose used elsewhere to describe cultural competence. The American Psychological Association, in a set of multicultural guidelines for psychologists, declares that "psychological service providers need a sociocultural framework to consider diversity of values, interactional styles, and cultural expectations in a systematic fashion. They need knowledge and skills for multicultural assessment and intervention."[4] The Center for Substance Abuse Prevention, a federal agency under the Substance Abuse and Mental Health Services Administration, refers to cultural competence as "a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups."[5]

Like many other manifestations of multiculturalism, multicultural counseling can be traced to the good intentions of early civil rights struggles gone far astray. Born of the desegregation of the 1950s, the original goal of the movement we now know as multicultural counseling was the assimilation of blacks into mainstream America, especially into the workforce. In his excellent review of the movement, Dr. Morris L. Jackson cites a 1955 paper, "The Cultural Context of Guidance," published in the *Personnel and Guidance Journal*. As one of the first considerations of culture in the counseling environment, the paper challenged its readers by asking: "Should the counselor convey his own personal values to his client or should he restrict himself to techniques which enable him to assist the client to discover his own implicit values?" The *Journal of Clinical Psychology* also introduced the topic of psychotherapy for minority patients. A 1950 paper entitled "The Negro Patient in Psychotherapy" raised two questions that hinted at the development of today's more extreme manifestations of multicultural therapy: (1) What is the nature of the relationship between a minority patient and a majority therapist he perceives as racist, and (2) can a majority therapist respond to the minority patient as an individual rather than as a member of a minority group?[6]

Discrediting Traditional Therapy

Today, radical multicultural therapy is not concerned with the integration of racial groups but with discrediting traditional therapy as an oppressive manifestation of a white-dominated culture. The global view of cultural competence is forcefully advanced by Elaine Pinderhughes in her book *Understanding Race, Ethnicity and Power*, which has been influential in the cultural competence movement. "Culture-free service delivery is non-existent," she declares. "The differences between client and practitioner in values, norms, beliefs, lifestyles, and life opportunities extend to every aspect of the health, mental health, and social services delivery system, which is itself a cultural phenomenon."[7] Pinderhughes blames psychotherapists who pursue what she calls a "White, middle-class model" of therapy:

> Traditional mental health philosophy ... has valued directive approaches, individual responsibility, looking inward, self-understanding and insight, personal growth and change, resolution of dependency needs, verbal and emotional expressiveness and thinking problems through. This philosophy differs from that of non-White, non-middle-class cultures that may value directive approaches, change efforts directed toward the environment, working with extended family and other relationships and systems toward increasing interdependence, giving advice, and hands-on approaches from a powerful clinician.[8]

Cultural competence also challenges the hierarchical relationship between therapist and patient. This is what prompts multiculturalists to refer to patients as "clients," sanitizing the term "patient" lest it hint of dependence, vulnerability, or disempowerment. One author approvingly describes this as "a shift from the asymmetrical relationship between a dominant counselor and a passive client to one that empowers the client to discover resources within their own cultural systems of meaning to deal with their problems."[9]

Even university researchers are asked to modify their standards to accommodate the style and less-than-scientific approach of the local staff, untutored in research methodology, whose clinic population is being served. As part of its "Cultural Competence Series," the Center for Substance Abuse Prevention published a book entitled *The Challenge of Participatory Research: Preventing Alcohol-Related Problems in Ethnic Communities*. This book contains a chart (see opposite page) that details the differences between "traditional research" and "participatory research," another term for cultural competence. As the chart illustrates, participatory research involves a great deal of "co-control" and prefers "practical" results over "academic" or "scientific" approaches. The overall complaint about traditional research seems to be that it is more concerned with scientific knowledge than with

ALTERNATIVE MODELS IN ALCOHOL PREVENTION RESEARCH

	Traditional Research	Participatory Research
Goals	Advance Academic knowledge	Advance practical knowledge
	Evaluation of services	Intervention
Methods	Positivist and deductive	Interpretive and Inductive
	Standardized measurement	Measures generated in response to local situation
	Replicability	
	Experimental design	Quasi-experimental design
Researcher/ Community Relationships	Researcher controlled	Co-control
	Researcher separate from the community	Researcher a part of the community
	Objective through distance	Objectivity through reflexivity
Research Subjects	Passive subjects	Active subjects
Research Issues	Determined ahead of time	Evolving from experience in the community
	Demonstrate group "effectiveness"	Interventions through the community
Research Funds	Controlled by granting agencies	Co-control; access to resources
Data Ownership	Researcher owned	Community and Research
Research products	Scientific articles in	Community reports scientific journals and interventions

This figure is adapted from the models of Chesler (1991) and DeCambra et al. (1992).

CSAP, *The Challenge of Participatory Research*, Figure 1-1, at 13. See also footnote 5.

helping people — of course, without scientific knowledge it's impossible for mental health professionals to help anybody.

Presumption of Racism

Finally, white therapists must endure a ritual of self-loathing before multiculturalists will deem them culturally competent. A popular textbook for counselors, *Counseling the Culturally Different*, asks the reader: "As a member of the White group, what responsibility do you hold for the racist, oppressive, and discriminating manner by which you personally and professionally deal with minorities?"[10] The American Psychological Association seems to share this presumption that the caregiver is racist. In its multicultural guidelines, the association suggests that "psychologists might routinely ask themselves, 'Is it appropriate for me to view this client or organization any differently than I would if they were from my own ethnic or cultural group?' "[11]

Counseling the Culturally Different declares that counselors-in-training should be routinely subjected to this antagonistic treatment. "While cognitive understanding and counseling-skill training are important, what is missing for the trainee is self-exploration of one's own racism," it says. "Without a strong antiracism training component, trainees (especially Whites) will continue to deny responsibility for the racist system that oppresses their minority clients."[12]

The views expressed in *Understanding Race, Ethnicity, and Power* and *Counseling the Culturally Different* may sound extremist and absurd, but the fact that the federal government, the American Psychological Association, and, to a lesser extent, the American Psychiatric Association are each promoting some form of multicultural sensitivity in psychotherapy is testimony to their growing influence.

Culture and the Doctor-Patient Relationship

To understand the dangers of multicultural counseling doctrine, one must first understand some important aspects of the doctor-patient relationship in the mental health field.

Psychiatry, whether practiced in a large public hospital or an exclusive private practice, involves building a unique, complex relationship with each individual patient. For severe psychiatric disorders, such as schizophrenia, bipolar disorder, and major depression, the psychiatrist can render a diagnosis and prescribe medications to control disabling symptoms. Psychotherapy for life problems, however, does not follow this standard medical model as closely. It requires the exploration of another person's emotions, experiences,

through the patient's eyes and apprehend his personal narrative, rich with coded symbols and idiosyncratic meaning.

One paper on how patient-therapist dynamics can be shaped by cultural themes includes the following examples:

- An Asian-American female psychologist working in a VA institution was assigned to conduct a psychological evaluation on a Vietnam War veteran. During the initial session, the White male client left the room exclaiming: "I cannot work with you. I know that you are trying to help me, but I feel as if you are my enemy."[13]
- A White male working with a Latina therapist was struggling with his feelings of marginality stemming from a childhood plagued by physical illness.... He stated to his therapist that he felt she could empathize and help him with his residual marginality due to her membership in an ethnic minority group and consequently her exposure to social marginality.[14]

In these cases, cultural factors played a role in the doctor-patient relationship, but these patients' particular psychological reactions were primarily a function of their own highly personal psychodynamic structures.

Culture has an influence on personal identity, but it is one influence among a great many, and it is not determinative. For this reason, psychiatrists must evaluate cultural influences the same way they evaluate every other influence: individually, one patient at a time.

The Dangers of the Cultural Competence Doctrine

The cultural competence doctrine is dangerous because it substitutes group-based generalizations for individual evaluations. It disenfranchises the therapist by dictating, in advance, how cultural issues for members of specific racial groups should be approached. Instead of permitting doctors to investigate the cultural life of each patient separately, multicultural therapists impose a one-size-fits-all cultural diagnosis to be used on all minority patients. Operating under these restrictions, the therapist cannot help but misdiagnose the problems of minority patients who don't fit the multiculturalists' mold.

Stereotypes

Often, cultural competence requires acceptance of blatant ethnic stereotypes as the basis for psychological treatment. Consider the following examples:

- "The Asian American's greater social awareness causes him/her to be somewhat more sensitive to racism and to often react with overt anger or militancy."[15]

- The therapist should "avoid linking mental problems [of African Americans] to parents' behaviors; these problems result from environmental conflicts in society."[16]
- Regarding Hispanic patients: "Time is not a fundamental variable; do not ask a [Hispanic] client reasons for being late to therapy."[17]

The Center for Substance Abuse Prevention's book on alcoholism research in ethnic communities contains the following patronizing and exaggerated admonition from Janet Mitchell, who runs a substance abuse treatment program for pregnant women in New York, on doing research in "communities of color":

> Many people around the research table still have some learning and growing to do. Researchers need to acknowledge and accept the following:
>
> - Understand that in African American communities, there is still the fear of genocide and of being used as guinea pigs.
> - There is the perception that you, as researchers, are taking from the communities and not leaving anything. That the community is a "means to an end" to benefit *your* career. That neither you nor your research findings benefit the community in any way that the community can document.
> - There is also the fear that the basis of your prevention programs is "I (the researcher) will tell you what I think you should do and how you should do it (my design, my theory, my hidden agenda?)," as opposed to "Tell me how you think I can help you."[18]

While it is true that many black people harbor suspicion about participating in medical research after revelations about the horrific Tuskegee experiments, in which effective antibiotics were withheld from black men with syphilis, Mitchell is presumptuous and strident — not unlike the authors of *Counseling the Culturally Different*, who declare that "the world view of the culturally different client who comes to counseling boils down to one important question: 'What makes you, a counselor/therapist, any different from all the others out there who have oppressed and discriminated against me?' "[19]

Trained therapists know that they must approach each new patient with an open mind — aware that cultural variables may affect assessment and treatment of some patients more than others, while not making advance assumptions about these factors. But impressionable trainees and others who

have been convinced that different principles of human engagement apply to minority patients risk distorting the doctor-patient relationship by believing, *a priori*, that minority patients are certain to be hostile.

Excusing Dysfunctional Behavior

Another problem with multicultural therapy is that it encourages therapists to excuse possibly dysfunctional behavior as misunderstood cultural behavior. Culturally competent doctors are overly vigilant in searching for cultural explanations of behaviors that otherwise would be diagnosed as signs of mental illness. The patronizing ethnic stereotypes promoted by multicultural therapists provide excuses for overlooking important symptoms of psychological disorder. For example, the American Psychological Association's guidelines for cultural competence advise:

> Psychologists [should] seek to help a client determine whether a "problem" stems from racism or bias in others so that the client does not inappropriately personalize problems.
>
> **Illustrative Statement:** The concept of "healthy paranoia," whereby ethnic minorities may develop defensive behaviors in response to discrimination, illustrates this principle.[20]

And Elaine Pinderhughes warns therapists:

> In assessing and treating psychopathology, clinicians must recognize that cultural differences are not deviances. While delusions are false beliefs, the criteria of false must be culturally appropriate to the heritage and experience of the patient rather than to those of the clinician.[21]

Doubtless it is a major task of the therapist to help patients distinguish between what is real, what is perceived, and what is wholly imagined. But given the modern prohibition against appearing "insensitive," culturally competent therapists might be reluctant to challenge a patient's perception that racism is the cause of his problems. There is reason to be concerned that cultural competence will begin to encourage underdiagnosis of psychopathology in minority patients.

Undermining Serious Discussion

Finally, cultural competence doctrine is dangerous because of the effect it has on other, more legitimate issues in the mental health field. The most prominent of these is the ongoing debate over whether minorities receive

adequate mental health care or are underserved by the current system. Diagnostic bias — the charge that blacks and Hispanics are overdiagnosed with schizophrenia and underdiagnosed with depression and bipolar illness — is another topic of considerable attention among psychiatrists. On both of these issues the available research is inconclusive, and further study is certainly warranted. But instead of approaching these unresolved questions in a straightforward manner, radical multicultural therapists promote identity politics as a cure for the alleged racial ills of the mental health field — at best distracting attention from legitimate issues, and at worst undermining serious attempts to address them.

The "Cultural Competence and Diversity Program" at San Francisco General Hospital

San Francisco General Hospital, a subsidiary of the University of California at San Francisco, is home to the most prominent cultural competence program in the United States. The "Cultural Competence and Diversity Program" demonstrates the flaws of multicultural therapy.

The program began in the 1970s, when San Francisco General created a specialty ward for Asian patients. The program was created to address the language barrier many recent Asian immigrants faced when seeking mental health services. By centralizing their staff members who spoke Asian languages, the hospital found that it could improve its service to these patients. The need for language services was real — what little quality research has been done on some forms of multicultural therapy has found that overcoming these language barriers is the only significant benefit of such therapy.[22] The Psychiatric Department of the University of San Francisco Medical School was awarded a well-deserved Certificate of Significant Achievement by the American Psychiatric Association for extending care to previously underserved populations.

But multiculturalism soon replaced the language barrier as the rationale for the program, and for the similar Latino program that served Spanish-speaking patients. Programs for other oppressed groups soon followed.

Dr. Bob Okin, Chief of Psychiatry at San Francisco General, describes the hospital's current procedure for assigning patients: Each patient is assigned to a treatment unit, or "team," specializing in a specific group — blacks, Asians, Latinos, gays/lesbians/bisexuals, women, and the HIV-positive. There are no general-service teams, only specialized teams. Each team is guided by a "curriculum," which specifies the proper procedures for treating members of the relevant group. Dr. Okin insists that the staff and patients are not rigidly segregated by group, but he says the hospital makes an effort to put staff and patients of the appropriate group into each ward, and with the three ethnic specialties it has succeeded in keeping teams and their patients at least 50 percent of the appropriate group.[23]

The only patients without teams of their own are uninfected white male heterosexuals. Dr. Okin says these patients are assigned to specialty teams on the basis of bed availability. This means that each straight white male patient will end up in the care of a team specializing in blacks, Asians, Latinos, gays/lesbians/bisexuals, women, or the HIV-positive — whatever team happened to have beds free when the patient came in for treatment. Dr. Okin says this does not cause any undue problems with providing services to white male patients, because each team has doctors on it who are white males themselves.[24]

San Francisco General has no plans to study whether the Cultural Competence and Diversity Program is providing improved care to its patients, but one can evaluate the program by reviewing the "curricula" provided for the specialty treatment wards.

The Black Focus Program

"The Black Focus Program at San Francisco General Hospital is an inpatient psychiatric unit that emphasizes the biopsychosocial factors affecting the African-American mental health consumer,"[25] says the program's mission statement. The only "biopsychosocial factors" identified by the curriculum are based on the racism of psychiatrists, who allegedly focus on pathologies among blacks and black families to the exclusion of "positive characteristics." The mission of the Black Focus Program seems to be the delivery of non-racist services, where "racist" is defined expansively:

> What are appropriate and healthy responses to conditions of society are often interpreted as "pathological" and unsuitable behavior. The viewing of Blacks as "disadvantaged," denying the significance of the patient's Black identity, the increased rate of institutionalization of non-whites, the higher rates of major thought disorders and lower rates of affective disorders, the inappropriate use of medication, and lack of objective and non-biased epidemiological studies of Blacks are all subtle forms of racism.[26]

By this reasoning, anything that finds blacks to be worse off than whites (higher institutionalization rates, studies showing the breakdown of the family among blacks) is proof of racist psychiatry. "All of us have been raised in a racist world," declares the curriculum, "inundated by myths, distortions, and stereotypes of Black people, and all of us, irrespective of our cultural backgrounds, have been wounded and stunted by racism."[27]

Dr. Michelle Clark, head of the Black Focus Unit, elaborated on these themes in a speech at the 1996 annual meeting of the American Psychiatric Association. Before speaking, she declared that she would "demonstrate my

biculturality" by following the "traditional West African practice" of offering respect to her elder — in this case, another doctor on the stage — and asking permission to continue. Having received permission, she offered to take the audience on an "anthro-bio-psycho-social-spiritual tour" of the Black Focus Unit. Referring repeatedly to "people of African descent," she declared that "science is practiced in the context of society. This includes the science of psychiatry. And it is influenced by the power relationships of the given society, so that knowledge — or what passes for same — may be used as an instrument for subjugation or liberation." And given "the lasting power differential which we refer to as racism," therapists must learn how to properly treat black "clients" in order to liberate instead of subjugate them. Dr. Clark stated that there are four stages to obtaining this cultural competence: one moves from "destructiveness" to "incapacity and blindness," through "precompetence," and into "proficiency."

"We also work with our staff to not be afraid to engage in the kinds of dyads that historically might have led to legal action or possibly even damage and death, such as to have a white woman speaking to a black man," she said. And as an example of the difficulty of setting up the Black Focus Unit, she repeatedly referred to the "struggle" to get the hospital to provide appropriate grooming products. Apparently, black patients could not comb their hair with the "little tiny plastic black combs" provided to patients at the hospital, and this was damaging their "self-esteem." A slide picture was used to demonstrate this important aspect of care on the Black Focus Unit.[28]

The unit's curriculum says that it will "address the issue of racism as it affects mental health professionals emotionally. ... The resulting enhanced personal awareness of racism will improve the therapeutic alliance with the African-American mental health client."[29] Thus the staff of San Francisco General is presumed to be racist, and the Black Focus Program has taken it upon itself to re-educate the staff. One of its "educational objectives" for the staff is to "break down denial of one's own participation in racism."[30] Apparently there is no need to inquire whether any given staff member actually does participate in racism — if he or she claims not to, this is only "denial" that must be broken down.

Predictably, this hostile attitude towards psychiatrists has led to problems in the Black Focus Unit. The overpowering racial theme is perceived by some as interfering with what should be the first priority: patient care. Relations between the staff, mostly black, and the psychiatric residents, mostly white and Asian, grew so unbearably tense that Dr. Okin stopped assigning first-year residents to the unit at all. Several of the residents described an "anti-white atmosphere," and one former white resident reported feeling "blamed, somehow, for the patients' problems."[31]

African American Health Services Specialists

A certain percentage of the social workers, nurses, orderlies, and other non-doctor staff members on the Black Focus Unit must be certified by the San Francisco Civil Service Commission as "African American Health Services Specialists." The certification process, from which blacks are not exempt, entails taking a 32-hour course on African American Health Services and logging "1,000 work hours of direct health related service hours to African American clients."[32]

An information package distributed by the San Francisco Department of Public Health describes a daylong course on "Culturally Specific Issues in Health Care Delivery: The African-American Client." The course, part of certification as an African American Health Services Specialist, includes study of "traditional folk remedies," and a "holistic approach to health." Included in the information package is a page entitled, "Quiz: Caring for Black Clients":

> What does your client mean when he or she says the following:
>
> - I think my baby has the tedder.
> - I fell out at church last week.
> - I'm getting poorly.
> - I was treated for bad blood a long time ago.
> - How can I have high blood and low blood at the same time?[33]

Apparently, you can't treat black patients until you have mastered "black English." In fact, most black people don't speak anything like "black English." It is true that certain localized populations have distinctive speech patterns, and of course any good health professional will make himself familiar with the local idioms for illness. But raising this routine process to the level of a racialized training program is silly.

When logging the required 1,000 hours of service to black patients, applicants must specify work that has been performed in one or more of the following categories:

- Health counseling and therapeutic support for foreign born African Americans.
- Mediation services between African Americans and police or other authority figures.
- Rehabilitative services for African American clients in the context of historically difficult cultural change, oppression and depression.
- Group and individual mental health activities that are culturally specific and specifically targeted for African American clients.

- Psychological tests or other assessment tools for African American clients (children and adults); and recommended or provided clinical or non-clinical intervention.
- Psycho diagnostic examinations and psychotherapy for emotionally disturbed, mentally ill and mentally disabled African American children.
- Interviewing and screening of African American clients to identify client's general physical and mental condition.
- Counseling activities and assistance with in-group therapy sessions.
- Case management services for appropriate agencies within and outside health care services.
- Investigation of the eligibility of African American applicants for psychiatric and medical care and services.
- Educational support and therapeutic care for youth and elder African American clients.
- Psychological and medical services for African American clients and family members as they relate to specific substance issues.
- Health education services that target African American clients (e.g., HIV, substance abuse, hypertension, depression, etc.).
- Disease control programs targeting African Americans (e.g., hepatitis, sexually transmitted diseases, T.B., etc.).
- Medical or psycho/social services for African American homeless.[34]

This list of activist causes — mediation with police, treatment of the homeless, treatment "in the context of historically difficult cultural change, oppression and depression," etc. — may or may not be related to the job requirements of San Francisco General Hospital or the health needs of its patients.

One problem, apparently not considered by those who set up this system, is that the creation of a specialty in African American Health Services implies that those without the specialty are underqualified to care for black patients. General practitioners do not do jobs that are reserved for "specialists." Will doctors not designated as African American Health Services Specialists someday refuse to treat black patients, out of deference to cultural competence policies or perhaps for fear of a lawsuit? Only time will tell, but the prospect is there.

The Other Groups' Curricula

The "Asian Focus Curriculum" explains at length that different Asian groups — Chinese, Japanese, Korean, Indochinese, etc. — are different. The curriculum lists a number of reasons for this: Confucian vs. Buddhist

philosophies, languages and dialects, religions, immigration histories, and so on. It declares that "any generalization about cultural characteristics of Asian-Americans can be potentially misleading and should be seen in the context of 'ethnospecific' cultural diversity."[35]

The curriculum then proceeds to dispense platitudes and advice for treating Asian Americans that would apply to treating any patient: "Cultural traits may at times generate stresses and conflicts."[36] "Cultural practices may be either adaptive or maladaptive, depending on whether the application of such practices would lead to the resolution of conflict and the lessening of stress."[37] Doctors are advised to be sensitive, compassionate, and understanding, and to use an interpreter when interviewing people who don't speak English.[38]

The "Latino Issues Curriculum" reviews the history of immigration to California from Mexico and Latin America and lists educational objectives. These objectives include "understanding of the basic principles of engagement of Latino patients into treatment," "basic principles of practice when using interpreters," "understanding the effects of the refugee and immigration experience," "develop comfort with the use of interpreters," "awareness of racial stereotypes," and "compassion and respect."[39] As with the Asian Focus Curriculum, most of the recommendations for dealing with Latino patients are simply good advice for understanding any patient.

Similarly, the "Lesbian and Gay Task Force Curriculum" declares that therapists should:

- Be sufficiently comfortable and confident to inquire about the individual's sexual identity
- Be able to take reproductive and sexual histories
- Formulate treatment plans which are culturally sensitive and appropriate for gay and lesbian individuals
- Be able to engage the individual's partner, family, and community support system.

Therapists should also have "compassion and respect" and "appreciation of the diversity in the lesbian and gay community across ethnicity, age, gender, and class."[40] Of course, professionals treating heterosexual patients must also take reproductive and sexual histories, engage the patient's family and community support system, and show compassion and respect.

The "Women's Issues Curriculum" makes reference to the fact that male behavior was once considered the normative standard in psychiatry. This has not been true for a very long time, but it apparently justifies the

maintenance of a separate women's treatment ward. Educational objectives for the women's program include knowledge of the "heterogeneity of women's experiences," and "empowerment of women patients to make their own choices," as if these principles did not apply to male patients as well.[41]

Dr. Okin says that one reason women need this ward is the unique nature of violence against women. Some experts go even further than San Francisco General, arguing — not entirely without foundation — that women who have been raped or brutalized by men may benefit from sequestration in same-sex units. But on the whole the simple fact that a patient is female should not dictate her assignment to a same-sex ward and treatment with a woman therapist. Susan Egelko, who directs a substance abuse treatment program for pregnant women at Bellevue Hospital, finds that "having men in our program is critical for preparing the women to reestablish a connection with their babies' fathers and to work on establishing healthier social and intimate relationships with men."[42]

Finally, the "HIV Task Force Curriculum" does contain some useful information on the physiological effects of HIV and AIDS, particularly on the human brain. But this is mixed in with such pithy statements as: "The HIV virus may act as a psychosocial stressor, producing anxiety about the possibility of infection, acute depression upon learning of seropositivity, or bereavement at the loss of a partner to AIDS."[43] Who needs to be told that contracting a deadly disease can cause stress, anxiety, depression, and bereavement?

Conclusion

"My students want to know how to do black therapy, Hispanic therapy and so on," complains Dr. Morris L. Jackson of Bowie State University, one of Maryland's historically-black colleges. "I certainly don't know what black therapy is. What I can teach them are principles and basic techniques that apply to human beings."[44] Dr. Jackson is right: the patient is a human being, not a cultural puppet. As any truly competent therapist knows, psychotherapy can never be about celebrating racial diversity because it is not about groups, it is about individuals and their infinite complexity. By replacing individual analysis with group-based generalizations, cultural competence doctrine threatens to replace psychotherapy with a new multiculturalist approach that spends more energy separating patients into groups than treating them.

NOTES

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4 "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations," American Psychological Association Office of Ethnic Minority Affairs, reprinted in *American Psychologist*, January 1993, at 45.

5 Center for Substance Abuse Prevention, *The Challenge of Participatory Research: Preventing Alcohol-Related Problems in Ethnic Communities*, Department of Health and Human Services publication No. (SMA)95-3042, at 6 (Department of Health and Human Services, 1995).

6 "Multicultural Counseling: Historical Perspectives," Jackson, Morris L., from Ponterotto, Casas, Suzuki, and Alexander, ed., *Handbook of Multicultural Counseling*, at 3-16.

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12 Sue and Sue, *Counseling the Culturally Different*, at 6.

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20 "GUIDELINES FOR PROVIDERS OF PSYCHOLOGICAL SERVICES TO ETHNIC, LINGUISTIC, AND CULTURALLY DIVERSE POPULATIONS," APA-OEMA, AT 46.

21 PINDERHUGHES, *UNDERSTANDING RACE, ETHNICITY, AND POWER*, AT 17.

22 "COMMUNITY MENTAL HEALTH SERVICES FOR ETHNIC MINORITY GROUPS: A TEST OF THE CULTURAL RESPONSIVENESS HYPOTHESIS," SUE, FUJINO, HU, TAKEUCHI, AND ZANE, *JOURNAL OF CLINICAL CONSULTING AND CLINICAL PSYCHOLOGY*, VOL. 59, NO. 4, 1991; "THERAPIST/PATIENT MATCHING AND EARLY TREATMENT DROPOUT," GOTTHEIL, STERLING, WEINSTEIN, AND KURTZ, *EXPERIMENTAL THERAPEUTICS IN ADDICTION MEDICINE*, AT 169-176 (HAWORTH PRESS, 1994); "EMERGENCY CARE AVOIDANCE: ETHNIC MATCHING AND PARTICIPATION IN MINORITY-SERVING PROGRAMS," SNOWDEN, HU, AND JERRELL, *COMMUNITY MENTAL HEALTH JOURNAL*, VOL. 31, NO. 5, OCTOBER 1995; "INADEQUATE FUNCTIONAL HEALTH LITERACY AMONG PATIENTS AT TWO PUBLIC HOSPITALS," WILLIAMS, PARKER, BAKER, PARIKH, PITKIN, COATES, AND NURSS, *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*, VOL. 274, NO. 21, DECEMBER 6, 1995. MOST OF THIS RESEARCH STUDIES "MATCHING," THE PRACTICE OF ASSIGNING PATIENTS TO HEALTH PROFESSIONALS OF THE SAME RACIAL OR ETHNIC GROUP. THERE HAVE BEEN NO MAJOR STUDIES OF THE EFFECTIVENESS OF MULTICULTURAL THERAPY GENERALLY.

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41 "THE WOMEN'S ISSUES CURRICULUM," *THE ETHNIC, MINORITY, AND GENDER ISSUES CURRICULA*, AT 2.

42 SUSAN EGELKO, TELEPHONE INTERVIEW, DECEMBER 1995.

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44 MORRIS L. JACKSON, AUTHOR INTERVIEW, DECEMBER 1995.

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Linda Chavez, President